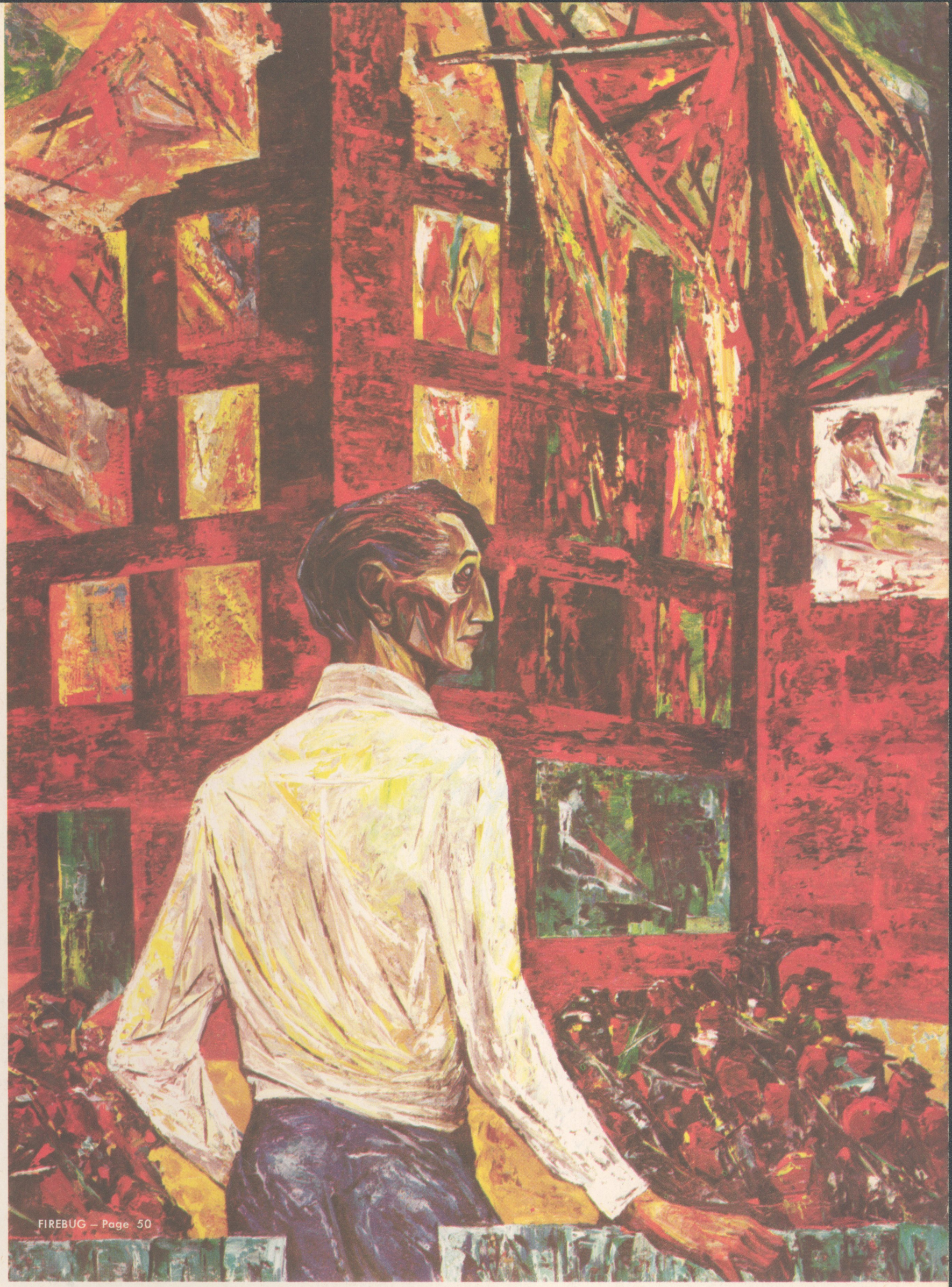
the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE



FIREBUG – Page 50

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THE COVER

As flames crackle and climb in the raging inferno he has ignited, what does the pyromaniac think of? Is he remorseful? Does he concern himself with the casualties which result from his act? Will he repeat it? See FIREBUG, on Page 50.

The painting on the cover was executed by Mr. Reese Brandt.

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THE PSYCHIATRIC BULLETIN

CONTENTS

Volume II ~ Number 3

Summer, 1952

Firebug

"Let's go! Hurry! There's a house on fire!"

How many times a year is the tragic scene enacted: a little coil of smoke puffs out at an upstairs window, often in the dead of night, and before the sleeping occupants are aware of it, the building is alive with smoke and flames.

A crowd gathers. Excitement-seekers cram the streets. Police must clear the way for the fire-fighting apparatus. Individuals take on the anonymity of a mob, and are subject to the primitive emotions of a mob. They stand about restlessly, fascinated by the horror before their eyes.

Shocking? Perhaps. Disgraceful? Not exactly. This is a commonplace emotional reaction to flamboyant disaster, a reaction shared by the great majority of people, whose capacity for true benevolence is yet imperfect.

There *are* unhealthier reactions.

Somewhere, among the morbidly curious there may be one who is experiencing sheer joy at the sight. Irresistibly drawn to fire, like the moth to the flame, he is the one for whom the popular term, "firebug", was originated. He may have ignited that fire deliberately. *Why?*

Fire as a Symbol

Nearly everyone can sense the peculiar fascination of a flame. Children, especially, are known to find fire stimulating and exciting. Magic properties were attributed to fire by primitive man, whose rites involving human sacrifice often centered around the "purifying" sacrificial pyre. As a symbol of power, fire is unequaled, by virtue of its ability to transmute the physical nature of things. It is little wonder, then, that some persons who lack the customary norms of emotional control should find fire irresistible.

The results which can be achieved by igniting a fire are monstrously out of proportion to the effort it requires. This further enhances the feeling of power which may be achieved with a trifling gesture. A force so powerful, yet so available, is readily seized upon by certain unstable examples of humanity. For each it may serve a different purpose.

Whatever their reasons, the people who set fires deliberately are not all psychotic, by any means. Some may be mentally retarded, but even this category cannot account for the entire group of people who resort to destructiveness by fire. For this reason, the term *pyromania* is apt to be misleading, since the individual to whom it is applied may not be a maniac at all. Indeed, he passes freely in many walks of life, his peculiar mental quirk entirely undetectable from his day to day behavior. In order to deal effectively with the firesetter, therefore, it is necessary first to discover his personal motivation for the act.

Firesetting for Gain

Most commonly encountered is the true arsonist, who sets fires for the uncomplicated purpose of monetary gain. In order to fulfill his purpose, he burns only structures which he owns, with the result that there are seldom any casualties. Premeditated, and enacted without the pressure of

inner turmoil, this is exclusively a legal matter and not a problem requiring psychiatric evaluation.

Firesetting for Sexual Gratification

Rarer, but more dangerous to society, is the individual who sets fires for the sheer joy and release it brings him. He takes no heed of the possible toll in property and human life. Unless apprehended, he is sure to repeat his crime. The person who sets fires for pleasure is emotionally sick, and actually, more a problem for the medical profession than the law.

Bromberg reports a patient who obtained such delight from watching fires that he ignited seventy of them within a period of a few years. In psychiatric literature, thorough case histories of pyromania are infrequent. The majority of "firebugs" who have undergone psychological examination, however, appear to be compelled from within by the force of aberrant sexual impulses. No single, clear, neurotic pattern dominates them all. There are several different manifestations of the perversion. For example, one type may derive extreme pleasure from the warm glow imparted to the surface of his skin by proximity to the flames. Another will obtain sadistic joy upon witnessing the collapse of the structure and the pain caused its occupants. A third may become sexually aroused by the mounting, consuming action of the flames. Still a fourth may receive the greatest pleasure from seeing jets of water bring the flames under control. Thus, it may be seen that the single act of incendiary crime may lead to sexual gratification in four separate spheres. One who becomes aroused by the sensation of cutaneous warmth may be so inhibited sexually that his skin is the principal erogenous zone of his body. The sadist is familiar to all as one who derives sexual pleasure from inflicting pain. The one who enjoys watching destruction may be stimulated by fantasies of mastery *by means of sex*, while the one who concerns himself with the extinguishing process may visualize *mastery over* the force of sex itself.

It is hard for the normally adjusted mind to conceive that a conflagration which takes its toll in lives could serve anyone as desirable. But the normal mind reasons without the distorted emotions of the neurotic. Most minds satisfactorily weather the storms of childhood fear concerning such matters as masturbation, sexual experimentation, and the desire to do away with one's elders. Some, however, never find a satisfactory solution to these ordinary conflicts. The fear surrounding them may become so great as to prevent any natural expression of the fundamental sex impulse. When the natural impulses become intolerably inhibited, the individual must seek substitute outlets for the things he desires, but cannot bring himself to do. The natural drive may then become *displaced*, into unnatural channels. In some twisted way, the behavior pattern selected serves to atone for the feelings of guilt or fear, and at the same time provides him with a sexual outlet acceptable to him. In the most serious forms of perversion, the substitute act itself is *the only means* for achieving orgasm. Thus, pyromania serves its perpetrator with sexual gratification.

The physician should have no difficulty in diagnosing this perversion, provided the sexual content of the reactions may be discerned. Such a person should certainly be removed from society. The firebug is in need of extensive and intensive psychotherapy. When it comes to helping him, however, even the specialist in psychiatry finds this among the most resistant of all forms of mental illness. The physician who recognizes the great potential danger in this type of perversion and who, therefore, recommends close supervision for any individual who reveals this tendency, may prevent untold tragedy from striking his community.

Firesetting for Revenge Against Society

In contrast to the sexual deviate, so strongly torn by inner stress, there is a type of person, familiar to physicians, who seems incapable of developing any feeling of right and wrong. Intellectually, he comprehends *the theory of* such a difference. It merely does not affect him, nor interfere with any of his acts. These are the "sharpies", who often consider it a great joke to victimize their fellow men. They comprise the most incorrigible group of delinquents, and are drawn to swindling, gambling or any route to easy and effortless profit. In some of these, there is an underlying cold contempt for organized society, which they feel is aligned against them. They may resort to firesetting purely for spitefulness and revenge. They would probably be just as happy tearing down a bridge. Naturally, such troublemakers are a menace to others, and if they cannot be controlled in any other manner, they should be confined. They are poor subjects for psychiatric aid. They may be guided into more acceptable behavior, perhaps, by the hope of greater gain for themselves. Their inability to benefit from past experience makes even this approach a precarious one.

Firesetting in Children

Firesetting in young children is much more prevalent than commonly supposed, yet usually lacks the sinister connotation found in adults. Boys, especially, are prone to build fires in and around their houses and yards, many of which cannot be accounted for on the basis of pure experimentation.

Yarnell reported on a series of 60 children, 58 of whom were boys, who once, or several times, had attempted to "set the place on fire". All of these children were the victims of some emotionally traumatic situation. Many showed other evidence of tenseness and anxiety, such as truancy, stealing, enuresis, running away from home, and various types of physical aggression. They were often disturbed by terrifying dreams, and expressed guilt and fear with regard to sex conflicts. Psychotherapy was used on this series of children, in an effort to discover their motives and eradicate the source of this behavior. It was found that these children were poorly adjusted to the home situation, some undergoing real tyranny at the hands of unsympathetic parents. They set the fires in an effort to "get even", not in reality, but symbolically, to put the childish sense of justice at ease. They set the fires with fantasies of burning up the whole family; then having satisfied the fantasies, often they would quietly extinguish them. Yarnell states that these children

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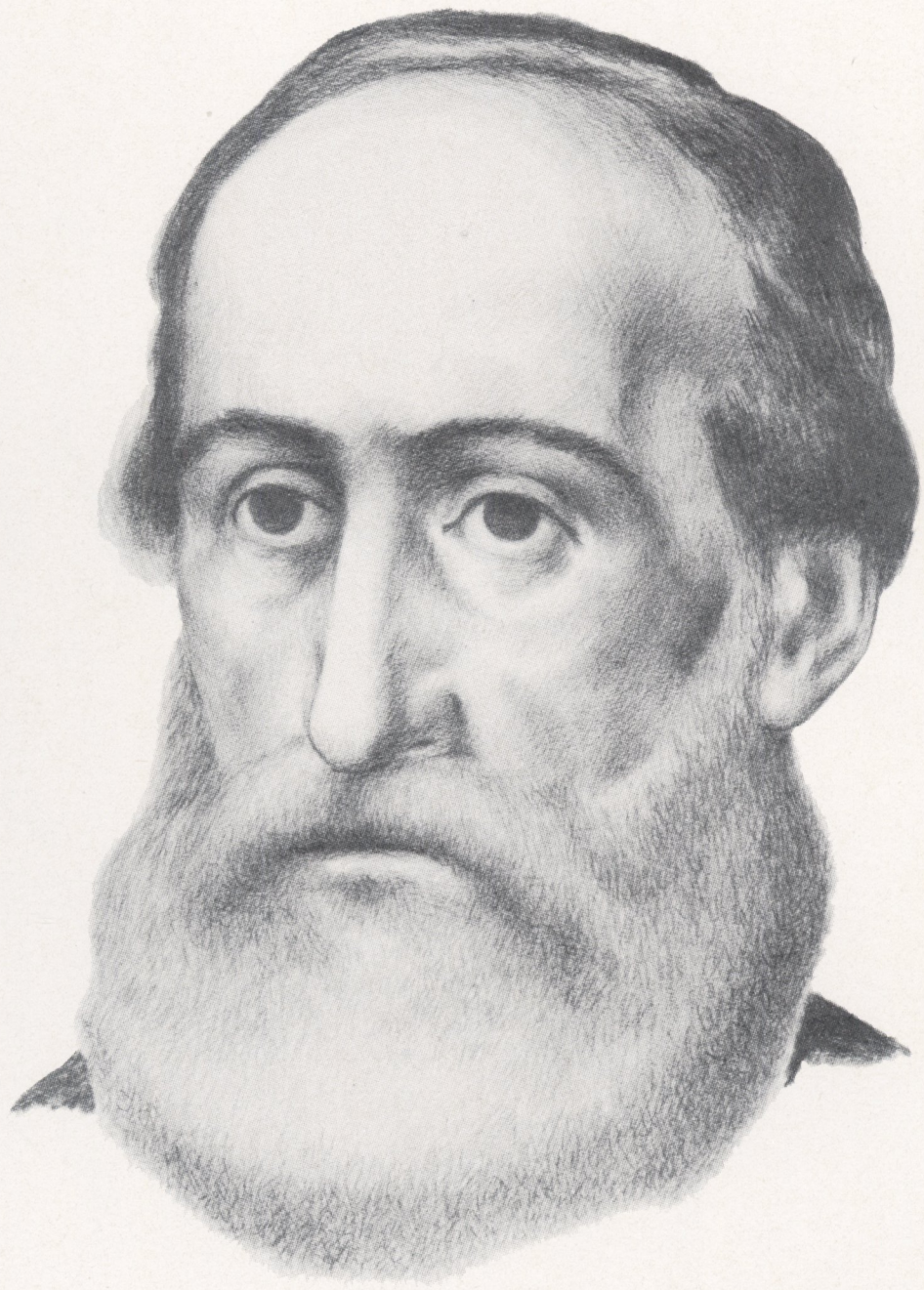

TUKE

AMONG the outstanding contributions to humanity is the work done by the Tukes of England in behalf of the mentally ill. A conscientious Quaker family, the Tukes for several generations endeavored to extend the Quaker philosophy of "man as friend to man" into the dismal reaches of the insane asylums of their day.

Daniel Hack Tuke was born in York on April 19, 1827. His great-grandfather, William Tuke, though not a physician, had begun a revolutionary trend by founding the York Retreat, an institution devoted to the gentle and kindly care of mental patients. Daniel's father, Samuel Tuke, carried forward the family tradition, devoting his life to maintenance of the Retreat. It is little wonder, therefore, that the young Daniel, growing up in this environment, shared the ambition of his forebears to improve the lot of insane patients.

In the Quaker tradition, Daniel attended a Friend's school. He received his degree in medicine at Heidelberg in 1853. In the same year he married and went abroad to visit the asylums of Germany, France, and Holland. Having spent many years of his childhood in observations at the York Retreat, Tuke had none of the fears and suspicions toward mental illness, then so commonly encountered, and persisting in lesser degree even to the present. In fact, Tuke berated his own colleagues for their lack of scientific objectivity in their attitudes toward the patients.

Inspired by the humanitarian work of Pinel in France, Tuke concentrated his attentions on the revamping of mental institutions throughout England. So outstanding was this work that even the asylums

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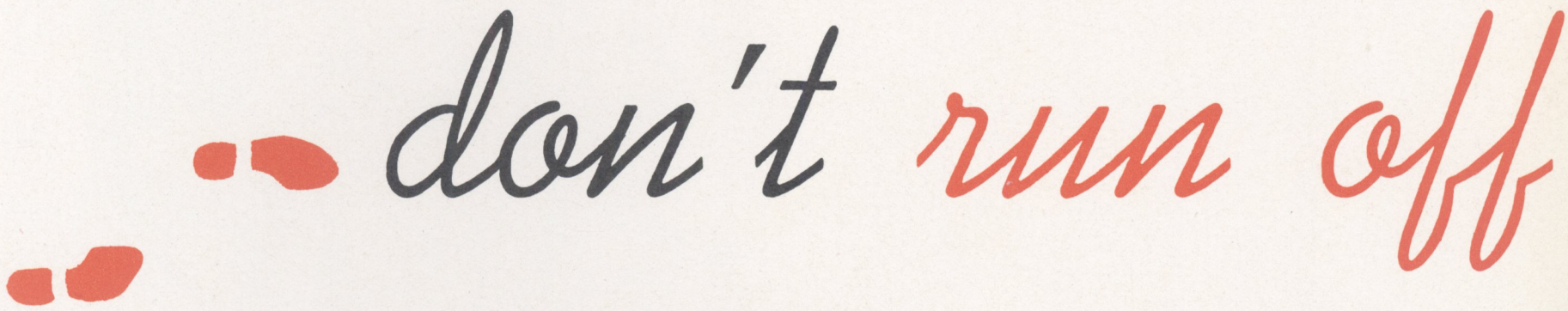


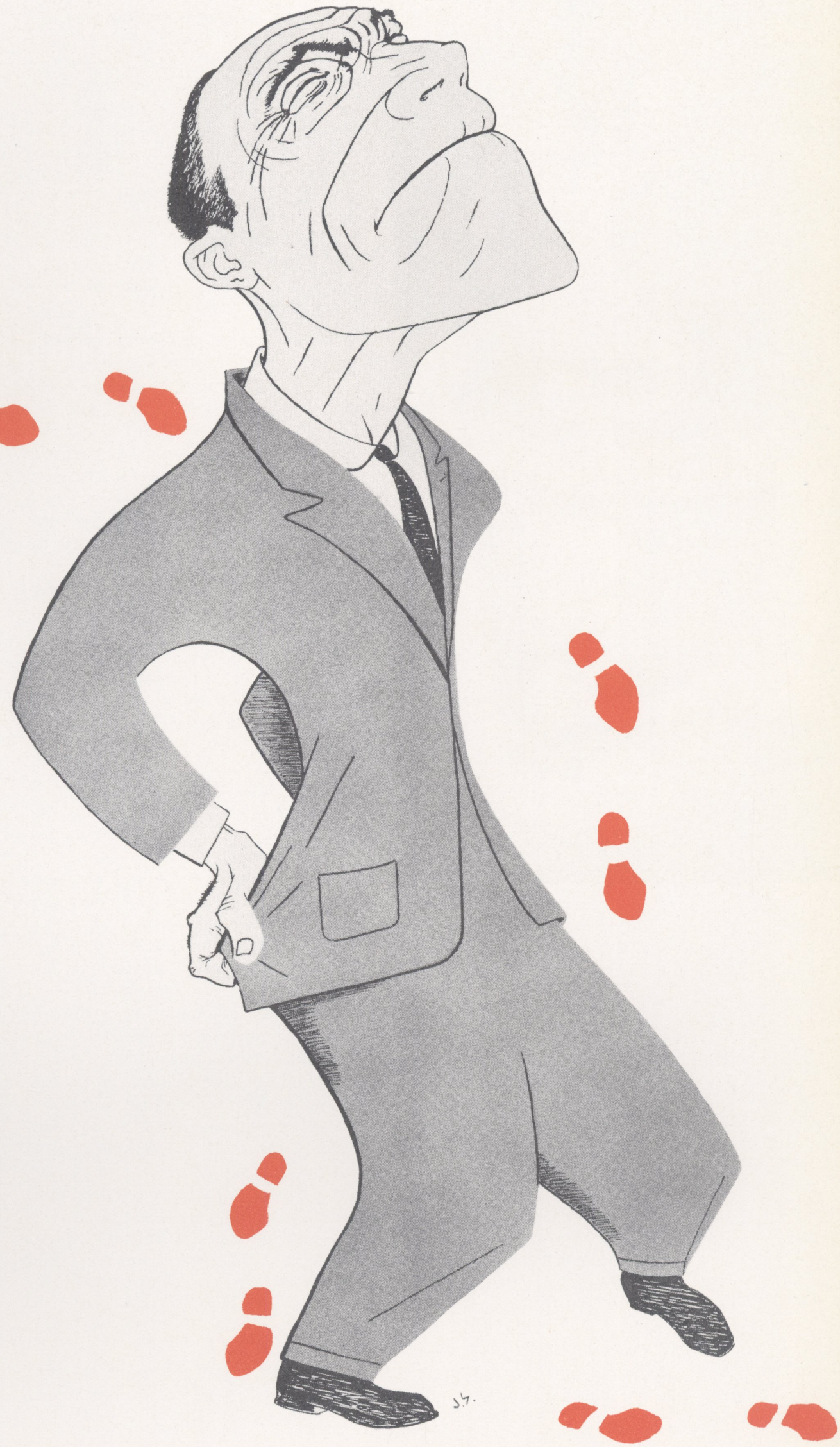
"THE MOST underrated thing in the world is a well-formed stool." So spoke a patient suffering from a debilitating bout of nervous diarrhea. Diarrhea often threatens at times least convenient for the victim. Situations charged with fear, anger, dread or generalized unrest may precipitate the attacks, greatly lessening the individual's immediate ability to cope with external problems. This symptom is reported to have occurred frequently under combat stress. And the phenomenon was featured in dialogue form in the brutally realistic fiction which followed World War II.

Nervous diarrhea is an extremely common compliant, and it affects various patients with different degrees of intensity. One may complain that he has two soft stools per day. Another may be disturbed by four or five stools a day, accompanied by the passage of gas and mucus. Still a third may suffer from a series of watery movements daily for two or three days, followed by long periods of apparently normal bowel evacuation.

The patient who suffers from "bowel trouble" usually waits a long time before feeling impelled to seek medical aid. Before presenting himself to his physician, he will probably dose himself with all manner of medications aimed at the relief of his fluctuating flux. His symptoms may include abdominal pain, nausea and bloating, weakness, and diarrhea alternating with constipation; his self-treatment may further serve to irritate the sensitive intestinal membrane and paralyze the natural rhythm of peristalsis. In describing his symptoms, the patient may report that his insides feel "all churned up". This is hardly surprising, because it is quite possible that he is seething with inner commotion and conflict.

The emotional component of diarrhea has been recognized by medical men for centuries. Diarrhea in conjunction with tension states is known to occur more frequently than can be accounted for by a diagnosis of any form of colitis. As a physical reaction to emotional stress, it is decidedly more of an annoyance than a danger to the patient.

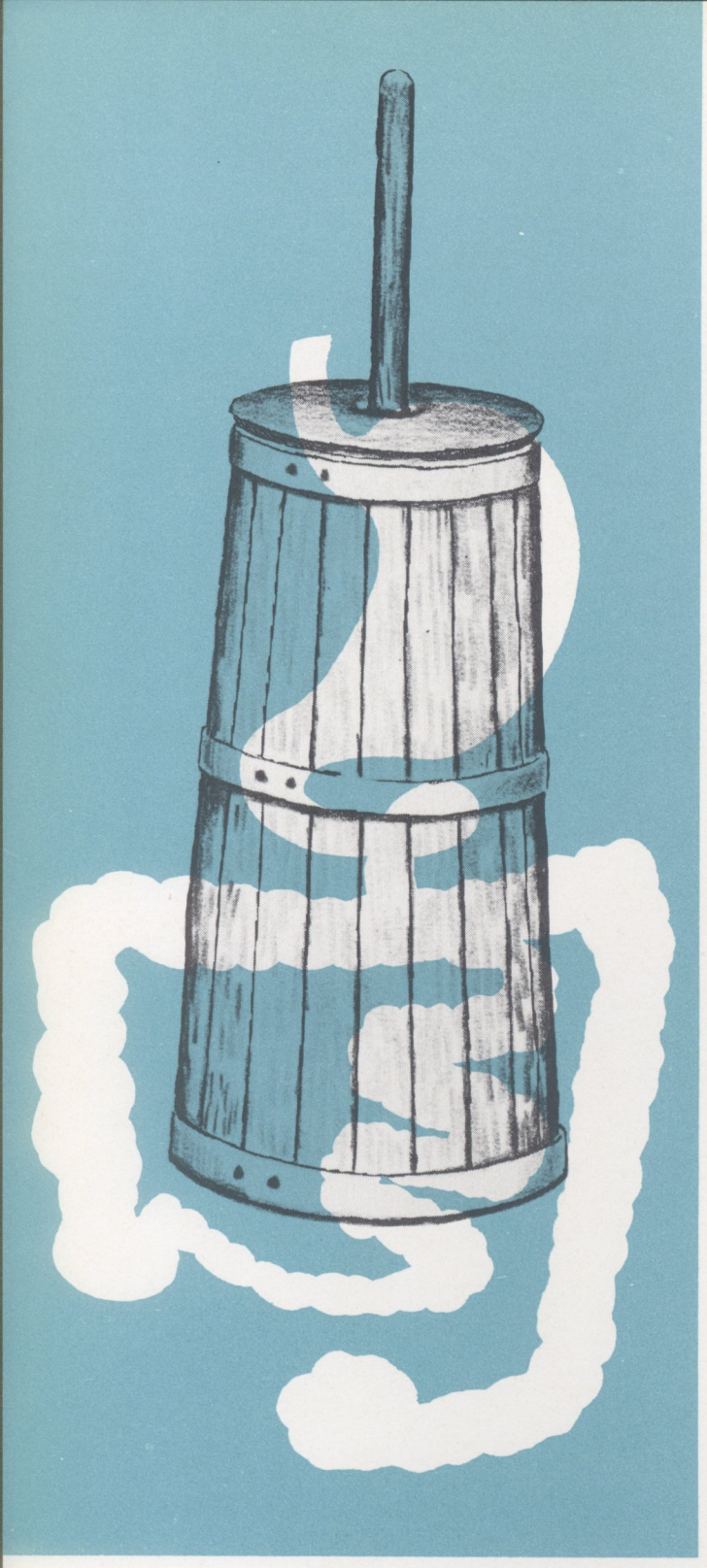
In psychosomatic illness, the process of interaction between mind and body operates just backwards from that encountered in purely organic disease. Thus, in somatic medicine, it is common to see an organic lesion which gives rise to physical symptoms, with a resultant state of mental distress. But in psychosomatic reactions, emotional strain tends to express itself first in feelings of anxiety, then in physical symptoms,



and later, as the symptoms become chronic, the patient may develop a physical disease. Therefore, diarrhea is frequently seen as a symptomatic forerunner of an irritable bowel, sometimes referred to as "mucous colitis", a psychosomatic disorder which tends to become chronic.

Irritable Bowel, a Functional Disorder

Some physicians use the term "colitis" indiscriminately to account for all varieties of gastrointestinal disorders. The term is inaccurate when no inflammatory lesion (as implied by the "itis") is actually present. Wide usage, however, has been given to the term "mucous colitis" in describing the functional condition which would be designated better as irritable bowel or spastic colon. Perhaps one reason for the prevalence of this imperfect terminology is that diagnosis is aided by



the descriptive adjective, since the passage of mucus in the feces is a visible indication that the intestinal mucosa is in a sensitive and irritable condition.

Two factors contribute to the etiological picture—an inherent predisposition plus the pressure of emotional stress. Everyone undergoes periods of mental unrest. These crucial states are capable of recording themselves in the body in some manner. Among that group of persons who have a sensitive gastrointestinal tract, the brunt of emotional crisis may be carried by the colon. Only the site of weakness is in any way constitutional. Precipitating factors are invariably emotional. A vicious circle may be set up if the condition prevails for a long period, for then any irritating substance within the intestines will be ill-tolerated, causing exacerbation of the symptoms. After repeated attacks, a form of conditioning may take place, which influences subsequent reflex activity in the colon. Thus, the vulnerable organ may remain in a state of chronic sensitization. If gastrointestinal upsets from infectious sources can be loosely referred to as "intestinal flu", then it is equally fitting to describe mucous colitis as "hay fever of the colon."

Differentiation of Irritable Bowel from Organic Colitis

The patient with irritable bowel may be alarmed by being told that he has "mucous colitis." It is well to protect the patient from undue worry by distinguishing his ailment from more serious conditions, such as *ulcerative colitis*, since the term "colitis" may be associated in his mind with some case of the ulcerative type which terminated fatally. This idea will not be conducive to relieving his emotional stress.

In order to make sure that no organic lesion is present, the physician may desire to make routine tests commonly employed for diagnosing ulcerative colitis. X-ray and proctoscopic or sigmoidoscopic examinations are valuable for obtaining reliable evidence of the condition of the intestinal mucosa. The importance of proctoscopic findings cannot be overemphasized, since the presence of a functional condition does not rule out the possibility of a coexisting, but unrelated organic lesion, such as early carcinoma. The patient may be comforted, however, by the knowledge that, according to many authorities, the irritable colon is no more susceptible to cancer than a normal one. Dr. Walter C. Alvarez states in his book, *The Neuroses*, "in my experience there is no more danger of cancer developing in a mucus-forming colon than in a normally functioning one. I have never seen any of my patients come to any bad end because of mucous colics. Some patients have to be reassured about the passage of mucus. They can be told that the body will not miss it or be the worse for its loss." (page 363).

It may be well in some cases to order microscopic examination of the stools, for dysentery-producing organisms. Even if the first report comes back negative for amebae, further investigation may reveal that an infestation is present.

The physician who, in addition to taking all the indicated physical diagnostic measures, also tries to find out what emotional difficulty may be contributing to the symptoms, may save his patient years of fruitless suffering. With regard to diarrhea, whether the complaint is a single occurrence, a recurrent reaction pattern, or the symptom of a chronic mucous colitis, the symptom itself may contain a clue to the basic conflict.

Surveys of Various Investigators

Analysis of a series of sixty cases by White, Cobb and Jones established the close association of diarrhea with the discharge of emotional tensions, such as fear, rage and resentment. It is the opinion of these authorities that mucous colitis should be regarded as a bodily reaction to emotional disturbance, rather than a distinct disease entity. In many patients, the condition is found in combination with other symptoms that are also suggestive of nervous origin. Study of the patient's total life situation, therefore, is essential for a comprehensive evaluation of the case.

Simple Psychotherapy is Frequently Effective

In psychosomatic disorders, a maximum of physical therapy can go unblessed by palliation, while a minimum of appropriate psychotherapy can accomplish gratifying results. This will be facilitated if the first physician to see the patient is able to diagnose his condition correctly. Effective psychotherapy is much harder to achieve when the patient has been under treatment directed to some organic ailment for months or years. If specific physical techniques or drugs are administered, the patient should understand that these are expedients used to obtain relief until the underlying basis for his symptoms can be found.

In some cases, the individual can accept the fact that he merely has a sensitive colon. Such patients may experience spasms of diarrhea without the presence of any particular

emotional disturbance. What they need most is reassurance that the condition, though annoying, is not balefully foreboding. Other patients, however, may be in need of a little psychotherapy specifically directed to their own emotional problems. The physician must know his patient well enough to determine whether he needs or can accept any delving into his emotional life.

If it convinces the patient that there is nothing organically wrong with him, the physical examination itself will constitute the beginning of psychotherapy. If the history shows recurrent attacks of diarrhea, and these can be shown to coincide with periods of mental stress, these stressful situations may be suspected as the precipitating factor. In many cases, the physician will recognize the connection between the emotional problems and physical symptoms quite readily, and still be unable to convince the patient that the two are related. Then, the patient may be asked, "When do these symptoms usually occur?" "What other things were going on?" "Was anything troubling you?" "Can you remember any earlier attacks during which some problem was preying on your mind?" In attempting to answer questions such as these, the patient may become aware of the particular conflicts confronting him at the time of the symptomatic episodes. For many times these disturbances are not completely lost to consciousness, yet the patient had never thought to examine his thinking from this point of view.

Should the discussions between the physician and the patient bring to light the basic conflicts in the patient's mind, the patient may not need much further psychotherapy. His functional symptoms, no longer needed to express bodily protest, will usually recede. It will be necessary for such an individual to meet his problems squarely, since the worries one faces with frankness are less apt to take a physical toll. Conflicts brought into the open may be attacked directly by conscious volition on the part of the patient. If he cannot fully resolve them, perhaps he can at least work out a suitable compromise with the troublesome situation, restoring the control to his own mind, instead of permitting his body to control him.

In discussing his emotional problems with a physician who keeps in mind the psychosomatic implications, the patient may arrive at an explanation of his trouble in keeping with his opinion of himself. He may be assured that when one's emotions are sensitive enough to set off a trigger mechanism involving the autonomic nervous system, those are the emotions of an alert, vital, and mentally active person. The dull, clod-like type of person rarely falls victim to psychosomatic disorders. Without a highly sensitive emotional apparatus such as his, he would be less likely to accomplish anything of a gifted, creative nature. An occasional upsetting of the vegetative functions is the price one has to pay for emotional sensitivity. Thus, the patient may be told that he is subject to psychogenic disorders and yet he may be spared the designation of "neurotic", which may be, to him, a humiliating concept.

A mind aware of its own conflicts can find many ways to minimize their effects. If not entirely dispelled, the emotional problems may be reduced to a position of relative insignificance to the patient. Facing the issues which had him baffled, he may deliberately disparage them, so that never again will they loom large and threatening to him. The desire to belittle one's obstacles in life must rank among the most fundamental of instincts. The act of persistent defecation may be the body's eloquent way of depreciating some disturbing situation in life.

As an alternative in some instances, when no such physical methods are employed, a similar implication is verbally expressed, by means of vulgar language intended to devaluate to the utmost one's immediate opposition. Indeed, who knows but that giving vent to such feelings verbally, the neurotic patient may save himself several discomfiting trips to the bathroom.

Suggested Reading

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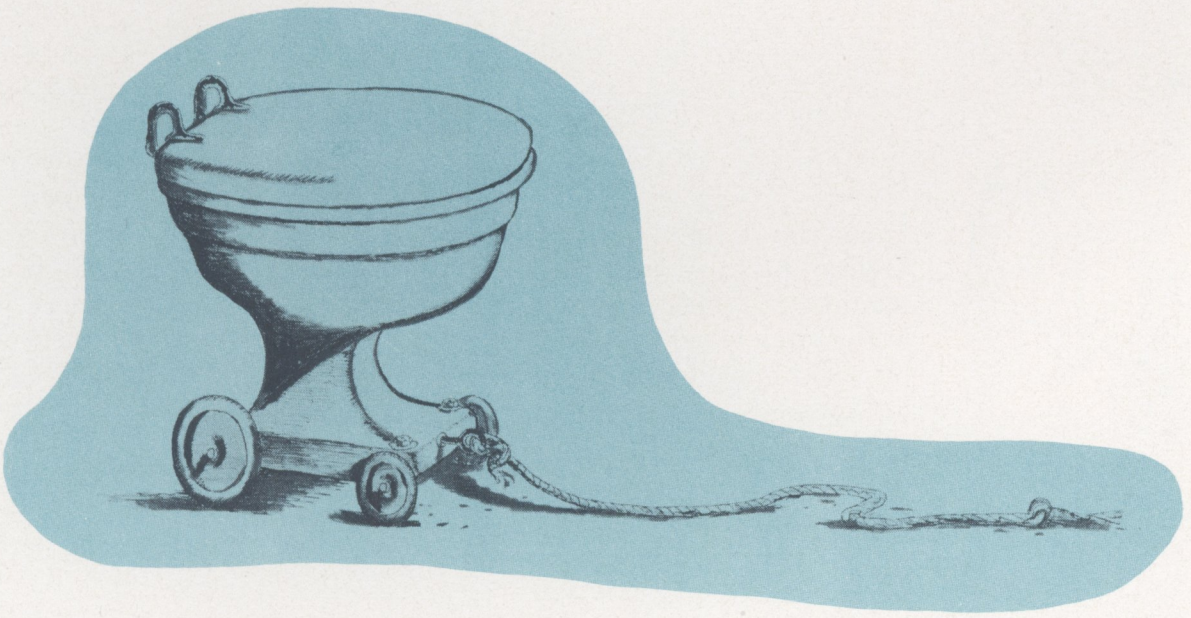

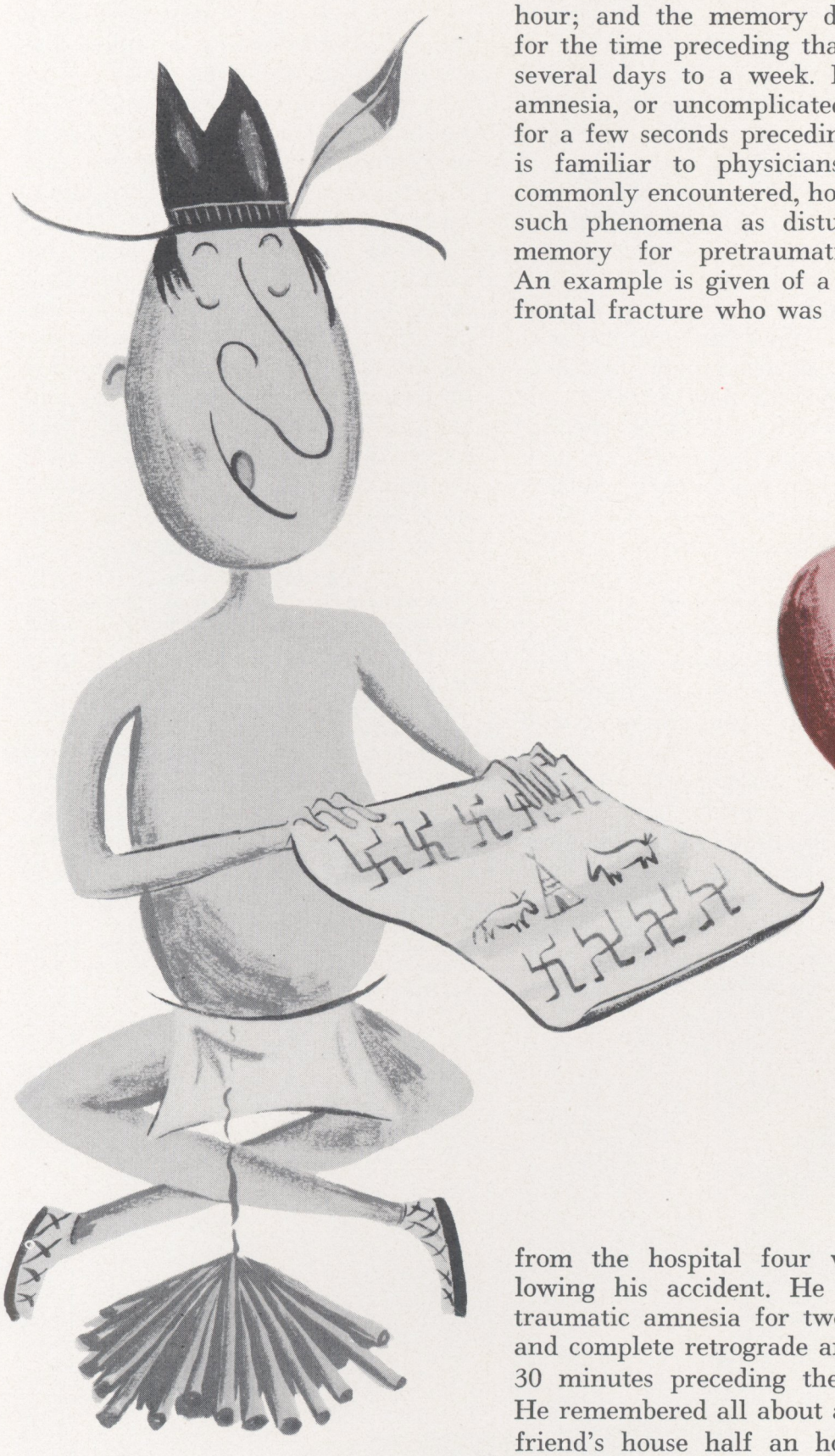

MEMORY DEFECTS AFTER HEAD INJURY: Several cases of retrograde amnesia following head trauma are reported, which were further complicated by spotty lapses of memory for days preceding the injury. In these instances, the period of posttraumatic amnesia varied from an hour to a week; the duration of retrograde amnesia varied from seconds to an hour; and the memory disturbance for the time preceding that involved several days to a week. Retrograde amnesia, or uncomplicated blackout for a few seconds preceding trauma, is familiar to physicians. Not so commonly encountered, however, are such phenomena as disturbance of memory for pretraumatic events. An example is given of a man with frontal fracture who was discharged from the hospital four weeks following his accident. He had posttraumatic amnesia for twelve hours and complete retrograde amnesia for 30 minutes preceding the accident. He remembered all about a visit to a friend's house half an hour before he was injured. However, his memory for the entire week prior to the accident was clouded and his time sense for that period was confused. He could not remember what he had done on a holiday three days before, nor could he recall several short trips he had taken during the week. Similar trips made in weeks preceding were adequately recalled. These patients were followed for several weeks to determine whether the memory disturbance would automatically reverse itself. It was found that, although some partial improvement was occasioned by telling the patient of his activities, most of the memory loss appeared to be permanent.

Attention is called to the parallel between this phenomenon and the residual amnesia sometimes found after electroconvulsive therapy. Patients who have had shock therapy may suffer from a transient inability to call to mind well-established personal information in their past histories. Memory gaps have frequently been reported in these patients and these, too, have been of a patchy, fragmentary nature, rather than absolute amnesia.

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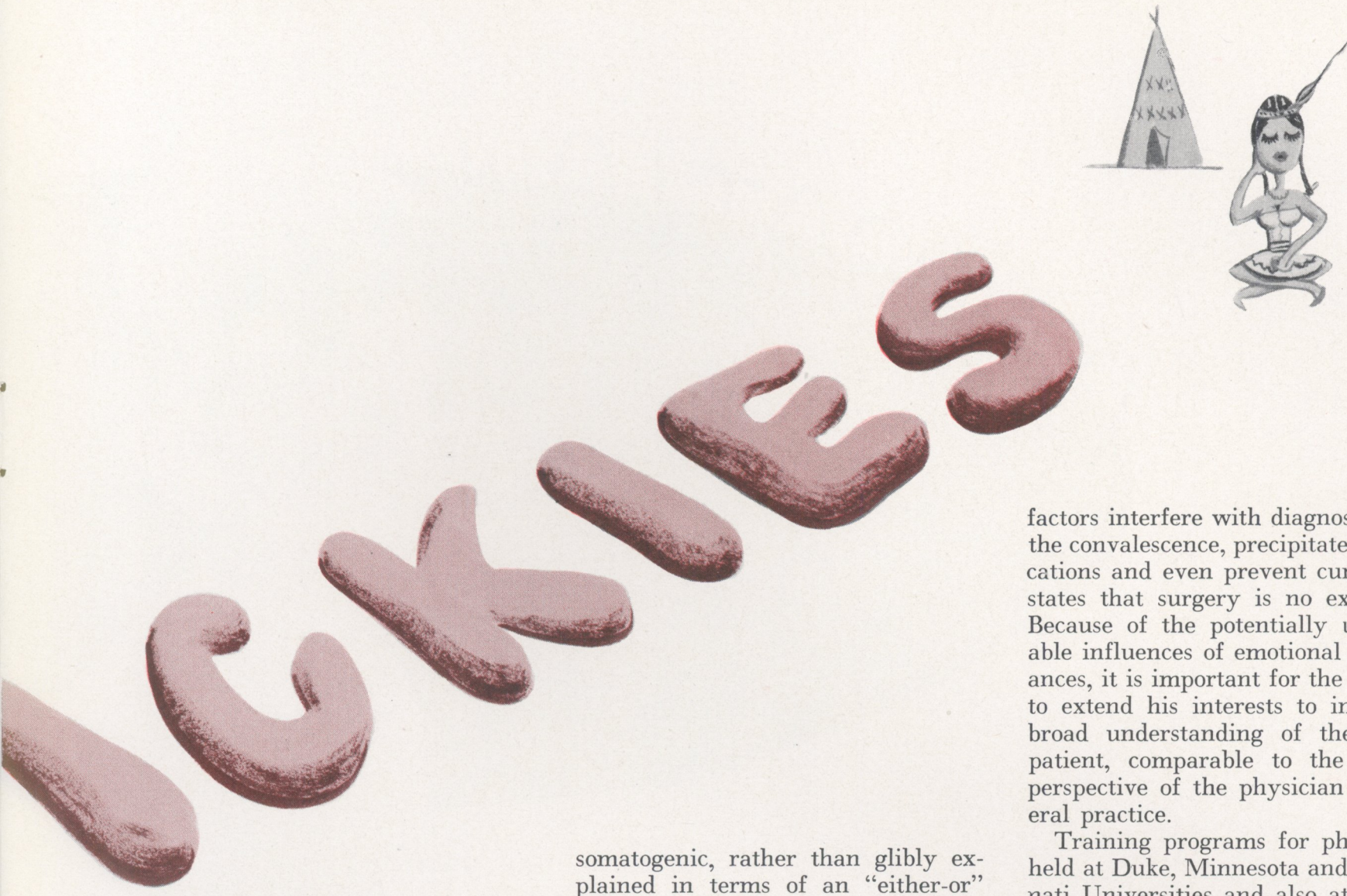


THEORY OF MULTIPLE CAUSATION IN DISEASE: In order to understand and eradicate a patient's clinical symptoms, it is frequently necessary to take into account the constant interplay between the emotional and the physical factors of illness. Any deviations from the norm in a person's anatomy, physiology, or biochemistry can have damaging results. Psychological and personality disturbances can further disrupt the functioning of the man as a whole. Rather than consider disease as purely psychogenic, or purely somatogenic, physicians are tending more and more to look for ways in which the patient is acted upon by many divergent influences. Keeping in mind the possibility of multiple causes, therefore, the physician finds that some conditions can be said to be *predominantly* psychogenic, or *primarily* somatogenic, rather than glibly explained in terms of an "either-or" concept. This is reminiscent of the early argument about the relative weight of heredity vs. environment. Much time and effort was dissipated in trying to arrive at an unequivocal answer before it was finally conceded that most individuals are complexly motivated by multiple genetic and environmental factors.

Since psychiatry is concerned with the study of the entire human organism, it must be on the alert for variable factors originating from many different sources. The whole man cannot be understood without a knowledge of his parts. Nor can the whole man be understood in terms of his parts alone. Man can be better understood in terms of interaction between all the parts as they function within the biologic whole. For a comprehensive study of man, a combination of all the biological sciences must be brought into play.

Benjamin, J. D.: Directions and Problems in Psychiatric Research, Psychosom. Med., 14:1 (Jan.-Feb.) 1952.

THE IMPORTANCE OF PSYCHIC FACTORS IN SURGERY: Dr. Philip Jacobson, Attending Surgeon at Petersburg General Hospital, observes that in all branches of medicine, "personality factors interfere with diagnosis, alter the convalescence, precipitate complications and even prevent cures." He states that surgery is no exception. Because of the potentially unfavorable influences of emotional disturbances, it is important for the surgeon to extend his interests to include a broad understanding of the whole patient, comparable to the overall perspective of the physician in general practice.

Training programs for physicians held at Duke, Minnesota and Cincinnati Universities and also at several hospitals indicate that, despite the surgical patient's great need for emotional reassurances, many house officers have an inherent resistance to any kind of psychological examination or therapy for the patients. The author notes that some physicians feel that the field of surgery is complex enough already. He answers this by saying, "rationalizations of this nature certainly were not accepted by the masters and intellectual giants of this or any other day."

Psychic problems may have some role in the illness the surgeon is called upon to eradicate. In surgery, as well as in other fields, organic pathology may follow from prolonged emotional disturbances. The surgeon who can give sufficient time and attention to securing the faith and confidence of his patient is in a better position to effect a satisfactory cure. By integrating the complete picture of the patient's illness, placing in correct perspective any subjective components of disease, he may be rewarded with quicker and smoother recoveries.

Jacobson, P.: The Importance of Psychic Factors in Surgery, Current Medical Digest, 18:39 (Nov.) 1951.

"I'M AFRAID those tonsils are going to have to come out."

"My little baby?" exclaimed the mother. "But Doctor, he's only two!"

The physician considered the case carefully. Certainly he took no pleasure in recommending surgery of any kind for so young a child. But in this instance, he felt that tonsillectomy could no longer be safely postponed.

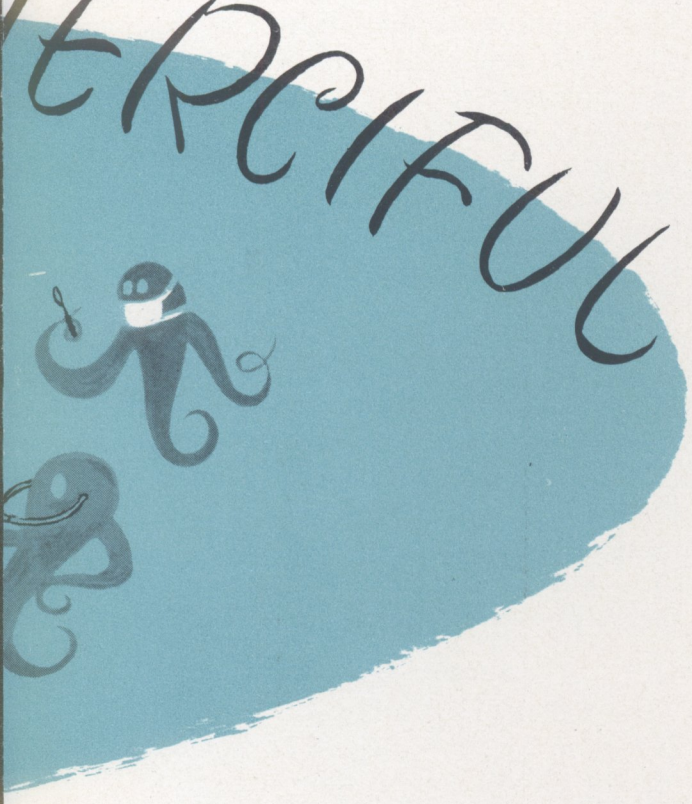
"There is no danger in the operation at this time of the year," he replied. "But if we don't get rid of this source of chronic inflammation, one of those ear infections may involve the mastoid, and that would be a dangerous complication indeed." The physician went on to explain the nature of the tonsil structure and lymphoid tissue in a child's throat and its particular vulnerability to infectious organisms. In spite of her initial outburst, the mother proceeded to state her objections clearly and unemotionally.

"It's not the surgery itself, Doctor," she said. "A little niece of mine had her tonsils out when she was six months older than my boy is, and she has had the most awful nightmares ever since."

"I have known that to happen, too," said the physician. "It is all the more unfortunate since a little foresight can so easily prevent it." He recalled various studies made by psychiatrists and pediatricians to determine the causes and the extent of emotional trauma in children following operations. Findings on emotional disturbance and behavior changes in youngsters following surgery have been carefully analyzed by several different groups, in an effort to keep these distressing sequelae to a minimum.

Coleman notes that the child's first trip to the hospital, usually for tonsillectomy, is too often fraught with parental deceit. Parents sometimes make it easy on themselves, but hard on the child, by misrepresenting the purpose of the trip to the hospital. While such a ruse may be helpful in getting Junior on the ward, it cannot fail to cause him resentment, fears, and insecurity. The small patient then has to face, not only a threatening and discomforting situation, but also the bitter knowledge that his parents have let him down, and may do so again.

The hospital is a new and unfamiliar place at best. Moreover, it is full of strange and unpleasant smells, peculiar noises, and routines



which are anything but reassuring to the patient. Some physicians tend to minimize the danger of psychic trauma to children who have undergone operations. Those who are not too far removed from their own childhood memories may be able to picture themselves in the child's place for a moment.

What first happens to him when he arrives at the hospital? First, he is undressed and put to bed, often in the middle of the day. This may seem to him unjust and punitive, a violation of his rights and inclinations. Then come the needles, the thermometers, and now and then, the enemas, which are even less pleasant for a child than they are for an adult. He sees no reason for this invasion of his privacy. The mildly restrictive measures are disturbing enough of themselves, when the patient is a youngster, incapable of understanding their purpose. It is small wonder that he becomes jumpy and upset. Before he can adjust to this situation, he is wheeled into a stark, white room, with bold lighting, frightening machinery, and masked strangers hovering about. The sight of the operating room is enough to create a panicky reaction in the patient. No sooner does he try to escape, however, than he is captured, held down, and suffocating measures are imposed which he easily construes as a threat to his very life. He fights a desperate battle with the anesthesia and loses consciousness, terrified by the thought that his loved ones have deserted him. When he wakes up, he is a fit candidate for behavior problems, hostility, phobias, and other neurotic manifestations.

Langford reports a study of 20 children suffering from anxiety states. In six of these, the condition was directly correlated with recent tonsillectomies. The children had all been poorly prepared for the experience, and their anxiety reactions took the form of "reliving" the administration of the anesthesia.

Levy conducted a survey of 124 children who had undergone surgery. Twenty-five of these, (20 per cent) suffered disturbing sequelae such as night terrors, exaggerated dependency, and negativism. Night terrors were more common among patients under two, and were accompanied by dread of darkness, doctors, nurses, and strangers. Negativistic responses occurred in the older children, and took the form of spitefulness, destructive outbursts, and temper tantrums.

Kaplan reported in detail the emotional reactions to tonsillectomies observed in 60 children at the Massachusetts General Hospital. Some of these children had been adequately prepared and were effectively bolstered by parental affection and attention during the operative experience. In these the traumatic effects were reduced to a minimum. Others, less considerately dealt with, reacted in various ways clearly indicative of emotional unrest. The fears with which they were grappling were obvious.

Fear of the Unknown

Any child who is brought to a strange place, left at the mercy of strangers, and seemingly abandoned by his parents, without a reasonable explanation, is done a grave injustice and his natural feeling of helplessness is thereby compounded. With sufficient preparation and reassurance, these reactions can be greatly lessened.

Case 1—Rose:

A little girl of three was brought to the hospital for a tonsillectomy. The child's mother, evidently seeking the easiest way to extricate herself, hit upon a solution that was the epitome of unfairness to the child. She told her small daughter that she would be back to get her "in just a little while". She then departed, leaving the little girl to the hospital attendants for the rest of the day and all the night. The child watched for her mother constantly, until she fell asleep. In the morning, she was huddled in the corner of her bed, desolate, subdued, and sad. She told the physician that her mother had come for her and taken her home, and that she had slept in her own bed the night before. She even seemed to believe it herself, so strong was her denial that her mother had forsaken her. Such a defense measure is a bitter solution for one so young, even though it may be unconsciously employed.

Case 2—Mary:

Mary was five. Her mother had been ill on several occasions before, necessitating frequent separations from the child. When Mary came to the hospital for her operation, she brought her doll, Sparky, with her. She displaced her worries to the doll, telling the physician that it was the doll who was going to lose the tonsils. After the operation, she said, "It's a good thing Sparky wasn't alone. She had her mother with her." This mother in miniature was "standing by" her baby, protesting the fact that in life, it does not always work out that way. Poignant though it was, the little girl's pretense, or displacement, helped to alleviate her fears.

Fear of the Known

Factors in the child's history which may be anxiety-provoking cannot be overemphasized in evaluating the child's ability to cope with the operative procedure. Even in the very young, attitudes are the product of one's life experience.

Case 3—Carol:

For three years Carol had enjoyed the company of a little sister. Then, when Carol was four, her sister died. Two years later, Carol had to have her tonsils removed. Quite naturally,

her fears were colored by her memories. For Carol knew that not all children grow up. Upon coming out of the anesthesia, she exclaimed with relief, "I didn't die! I didn't die!"

Case 4—Ann:

Ann was seven. Her mother had recently undergone a goiter operation. The child was well acquainted with the long and lethal-looking scar which traversed her mother's throat. When she spoke of her fears of the tonsillectomy, it became apparent that she envisaged her own throat, similarly cut from side to side. These fears were easier to console than to eradicate. She fought her anxiety best with the prospect of having ice cream following the operation.

Fear of Castration

Castration fears come into play more often than one might suppose when children are faced with surgery. Little girls may feel that already they have been deprived, somehow, of a masculine organ they once had. Boys, highly prizing their penises and believing that their little sisters have nothing even comparable, may fear that something dire might happen to these unique appendages of theirs. Parents usually fail to reassure them on this point. Some may implant stronger fears by threatening the child, "if you play with it, the doctor will cut it off." Even when the thought is not verbalized, the child who is shamed for touching his genitals may feel guilty and expect punishment through bodily harm to the offending organ.

Case 5—Richard:

Richard, at age 10, had even more reason than others to fear castration. For he had an undescended testicle, and surgery for this condition had been discussed in his presence. Evidently the matter had not been thrashed out to his satisfaction, because when he went to have his tonsils and adenoids removed, he was unduly terrified. For four days after the operation he refused to say a word. He moped; he would not eat; he drooled. When he finally did speak, the voice he used was weak and high. He felt sure that he had been emasculated. It took both time and patience to convince him that nothing had been cut below his throat.

Case 6—Peter:

Peter, a 13-year-old boy, was paralyzed with fear of his impending tonsillectomy. He knew nothing about the operation, nor would he listen to anything about it. He was cowed and uncommunicative. After the operation, he was depressed and melancholy in the extreme. For the next week, he slept poorly and had no appetite. He then confided to his mother that the surgeon had removed "something else" besides his tonsils. He believed, like Richard, that his genitals had been resected.

Conclusions

Of the 60 children in the group which Kaplan studied, 28 handled the situation in a manner which he described as "adequate". By this he meant they faced their fear directly and expressed their feelings about it in one way or another. Some set up a fuss, giving vent to tears or a show of temper, thus getting it "out of the system". Others acted out their worries in play, with toys, with other children, or with games. The children able to employ these defenses were not psychologically crippled by residual emotional disorders.

Of the 32 who were unable to master the situation while in the hospital, only four escaped emotional disturbance upon their return home. The rest developed such symptoms as nightmares, restlessness, overactivity, enuresis, depression, and defiance. While Kaplan states that this is only a preliminary study, he feels that it further clarifies the subject under discussion and indicates that surgery, of itself, is not the most traumatic factor among these children. The amount of anxiety aroused by the operation is largely dependent on the child's inner security and the manner in which he is prepared. Even the intensity of the child's fear need not determine the outcome, since so much of it can be allayed by the defense mechanism selected.

Preventive Measures

As Coleman points out, parental deception for the purpose of obtaining the child's cooperation in getting to the hospital, is inexcusable. If the total parent-child relationship is one of fairness, this will not occur. Parents who do their children the honor of a frank and reasonable explanation, however, will usually be rewarded by a minimum of panic reaction on the part of the children. This is not to say that a young child should be told outright that the physician is going to cut something out of him with a knife. He will not be conscious of that, anyway. But he can be prepared in advance for what he is to experience and given a few days to get used to the idea of going to a new place for a short time. He may be told that he will wake up in just a little while and his mother, or whoever is closest to him, will be with him. The explanation must, of course, be appropriate to the child's level of comprehension, but careful attention should be given to any apprehensions he may have. He should be prepared for some pain but assured that this will be kept to a minimum. If the child already knows and feels confidence in his physician, the ordeal will be made easier for him.

Levy suggests postponing surgery, whenever possible, until a child is three or over, since younger children have greater difficulty in adjusting to the separation from home. Kaplan corroborated the position of Levy

Please turn to page 68

FIREBUG

Continued from page 52

"after removal from the traumatic situation and after some psychotherapy, lose their tenseness, cease their terrifying dreams, and often will deny they ever had such ideas."

One of the most touching examples of youthful protest by means of fire is described by Erikson in his book, *Childhood and Society*. It concerns a little boy of four, removed from paternal influence by the war, and dominated by a perfectionist mother and grandmother. These two well-meaning but misguided women attempted to make him fit their concept of childhood, which happened to be somewhat goody-goody, pliable and weak. Unfortunately, the mother also spoke in disparaging terms of the child's father, from whom she was estranged. The boy was well on the way to becoming a dreadful little sissy when his father, a bombardier, returned from overseas for a visit. Filled with masculine glamour, and relating exploits which contradicted all the non-aggressiveness the child had been taught, the father represented a complete reversal of his established values. The father returned to the combat zone and was killed. Soon after that, the little boy began building and lighting fires in the back yard. Presented for psychiatric study, the child stated his reason quite simply. If they were German cities, he said, everyone would praise him for setting them on fire. The little son of a bombardier was trying the only way he knew to emulate his father, to be a man—a hero. His mother was advised to encourage his aggressiveness, but direct it into harmless sports and to revise the pattern of his upbringing into masculine channels. When the perfectionist feminine pressure was relaxed, the boy's personality was allowed to develop along more reasonable lines.

Most childish firesetting has some such logical explanation—distressing, in that it is a symptom of emotional strife, but not alarming because of unhealthy connotations. There are a few exceptions. Sadler reports a youth, for instance, who set fire to over twenty buildings before he reached the age of fourteen. In some children, whose hereditary emotional endowment and environment leave much to be desired, it is possible for the sexual conflicts of puberty to crystallize into perversions at an early stage.

With regard to pyromania, the physician's most effective work must lie in the field of prevention. When firesetting is seen as evidence of emotional suffering in the young, the physician faces an almost unequalled challenge for preventive psychotherapy. To his scientific and objective mind, there is no such thing as "just plain badness" in a child. The destructive tendencies which he reveals are but the symptoms of some problem which is too big for him. Whether he expresses this in firesetting, truancy, stealing, or by wetting his bed at night, the child is indulging a wordless protest at some real or fancied indignity in his life. If the physician has an opportunity to talk with the child, or to observe him at play, he may uncover the basic trouble much sooner than could the child's own parents, since he does not share their near-sighted perspective. He may discover that some injustice is really being done the child, by his parents—in the home—at school. Whether done maliciously, unwittingly, or in the name of a stifling devotion, the unfair treatment of the child must be eradicated before he can be expected to improve. Every physician needs to be something of a child psychiatrist these days, to help misguided parents with the understanding and advice they so sorely need. For in unearthing the roots of conflict from the troubled mind of a child, he may forestall the ultimate development of a stubborn perversion or an incorrigible delinquency.

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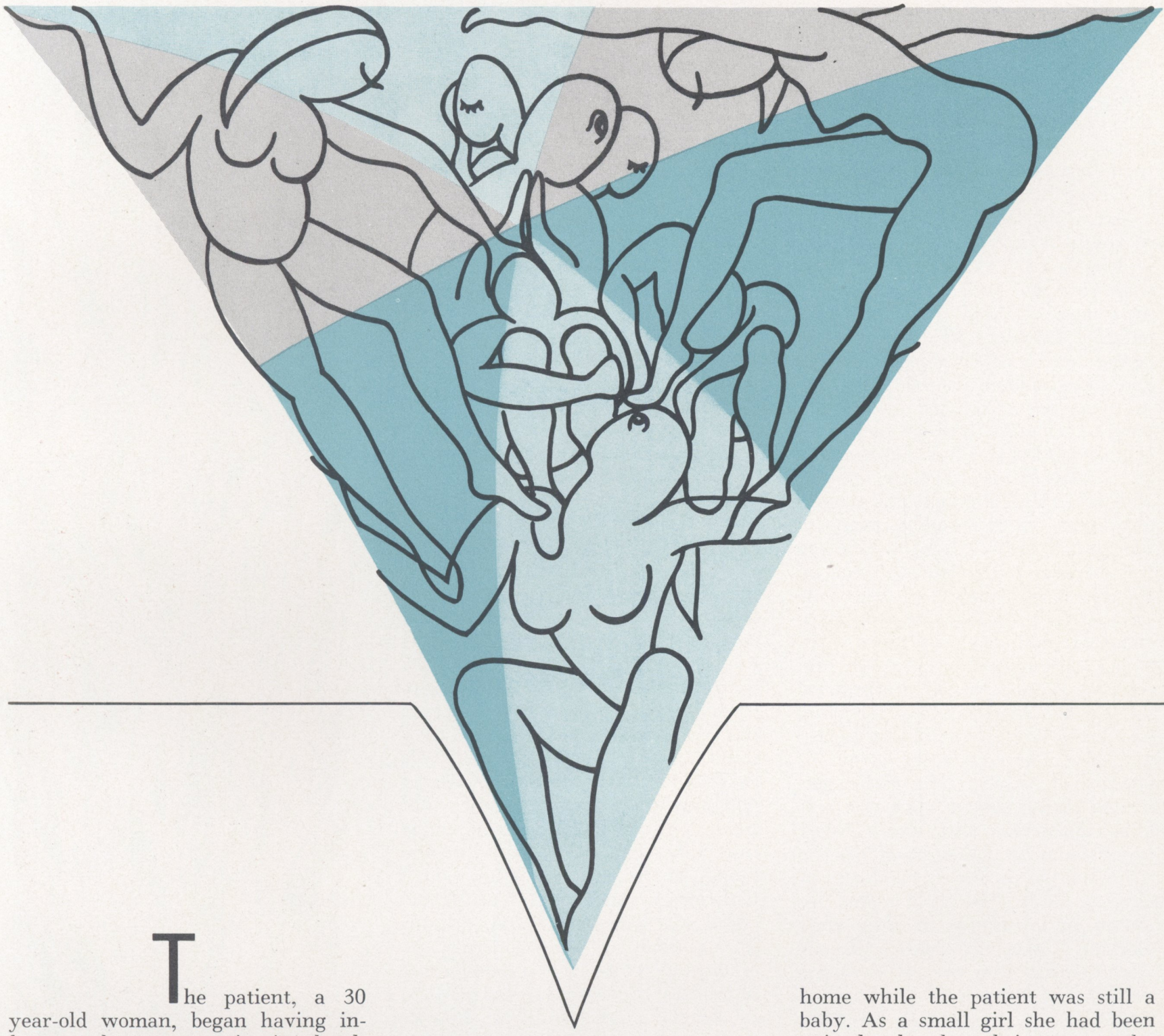
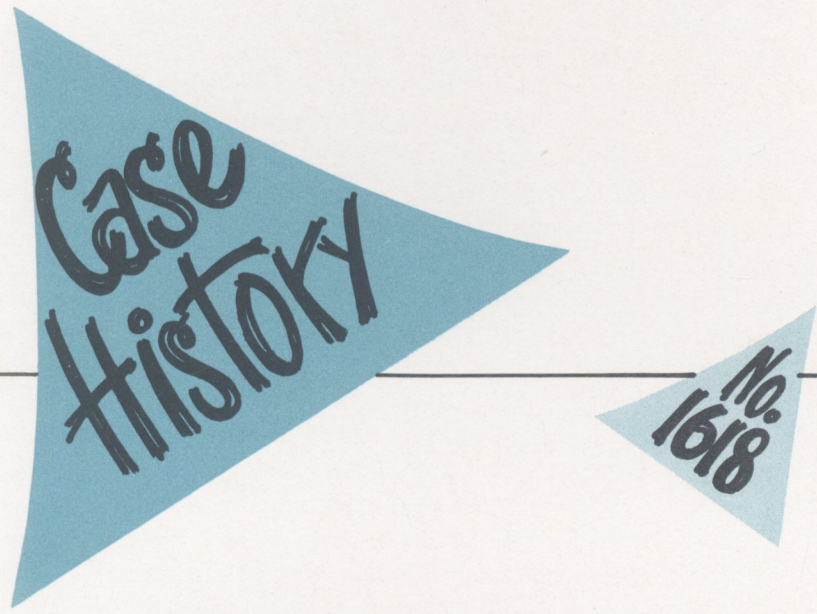


The patient, a 30 year-old woman, began having infrequent but severe migraine headaches about a year prior to referral. In the previous six months they had necessitated hospitalization several times and other symptoms had appeared. These were diffuse headaches, pain in the neck and back, dizziness and fatigue. These had become so bad preceding her first visit that she had been unable to carry on her work in the home and her husband's grocery store for the previous two months, and she became tearful and depressed. Her local physician had been able to give her some insight into the emotional element of her difficulties but she continued to get worse and he referred her to a psychiatrist.

DIAGNOSIS: Although some anxiety and depressive symptoms were present, it was felt that their importance was outweighed by the somatic complaints. Therefore, a diagnosis was made of somatization reaction, manifested by migraine headaches, muscular pain and tremulousness.

PERSONAL HISTORY: The patient was born in an east Texas town, the only child of her father's second marriage. There were three children by his first wife but only the youngest of the three, a girl nine years her senior, was close to the patient. The others were grown and had left home while the patient was still a baby. As a small girl she had been quite lonely, there being no nearby children to play with, so she spent as much time as possible with her father. He was an ineffectual man who disapproved of his wife's treatment of the child but did not intervene. He sought to make up for this with affection, approval and interest.

She was fond of her half-sister, who gave her attention and understanding and who protected her from the harsh, stern mother. This woman expressed her rejection in many ways without being physically cruel. The patient recalled saving up money for a pair of stockings for her mother's Christmas present, only to find them thrown in the wastebasket the next day. She was often



locked in the pantry for trivial offenses. The mother's attitude was critical and domineering in other ways and the patient soon got the idea that whatever she did was not good enough. These feelings were enhanced by the mother's constant praise of a girl cousin about the patient's age. As a result of this, she set unreasonably high standards of performance for herself, being unhappy if anything she did was less than perfect. She became overindustrious and never allowed herself to relax. When she grew older, the mother alternately warned her against boys and accused her of misbehavior with them.

Menarch was at 13. She had little previous preparation and was frightened by it. Instruction came from the older sister rather than the mother. Her knowledge about sexual relations was equally meager. She quit school in the tenth grade at 15 years of age to marry a boy five years older than she.

For the first time, the patient felt she had someone her own who really cared for her; she was very happy. In the second year of the marriage, a girl was born. This child, though intelligent, was congenitally deaf, for which the patient was blamed by her mother. A son was born two or three years later. After about three years, the husband became jealous and accused her of running around with other men. He started drinking heavily at this time also. Sexual relations, which had never been satisfactory, now became repugnant to her. The husband's jealousy and drinking increased to almost psychotic proportions and he threatened her life with knives and guns. During the last few years with him, she was awakened several times to find him standing over her with a weapon. At length, she separated from this man and, despite his threats, obtained a divorce.

She supported herself and the children with little help from their father for about three years. The girl was in a special school for the deaf. In the last year of this period, she met and married her present husband who had been divorced about the same length of time. A gentle man, he wanted to do many considerate things for her but she would not let him. Sexual relations, while no longer repugnant, were still unsatisfactory and regarded as a duty rather than a pleasure.

The mother-in-law at first accepted her and insisted that the couple live in one of her apartments, rather than in the husband's house, which was rented. About six months after the marriage, the husband bought a grocery store and the wife kept books and checked customers. The mother-in-law now came daily to the store, attempting to run it. Her carping and critical attitude, thinly disguised with an air of helpfulness, was directed primarily toward the patient. Whenever she was crossed, she would have such a temper tantrum that everyone feared she would have a "stroke". She began to make unfavorable comparisons between her present and her former daughter-in-law and to "throw up" to her all the favors she had done them, particularly emphasizing the rent-free apartment. While the husband sympathized with the patient, he did nothing to stop his mother. Her own mother had altered neither her attitudes nor her demands; thus the patient had spent the last six months in close contact with two elderly women who were hostile, critical, and controlling. Her working day was divided between the store and the home, where she had no additional help. In this situation, she found herself less and less able to carry on her duties in a rigid, perfectionist way.

MENTAL STATUS: The patient was a well-groomed, slightly obese woman who was complaining of head and neck ache. She was tense, tremulous and restless throughout the interview. Her well-organized thoughts were verbalized spontaneously and with great emotional pressure. She was moderately depressed and cried occasionally, but entertained no suicidal thoughts. Her main fears were that she would be unable to work both at home and in the store, and that eventually her husband would align himself against her with his mother.

TREATMENT: Since she lived some distance away and hospitalization was deemed unnecessary, it was decided that she remain in town with relatives and be interviewed daily. Thirteen consecutive interviews followed, interrupted only by week-ends. During this time she was treated with mild sedatives for her general tension. A threatening migraine was aborted with one of the ergotamine compounds. The vertigo responded well to Metropine with Scopolomine.

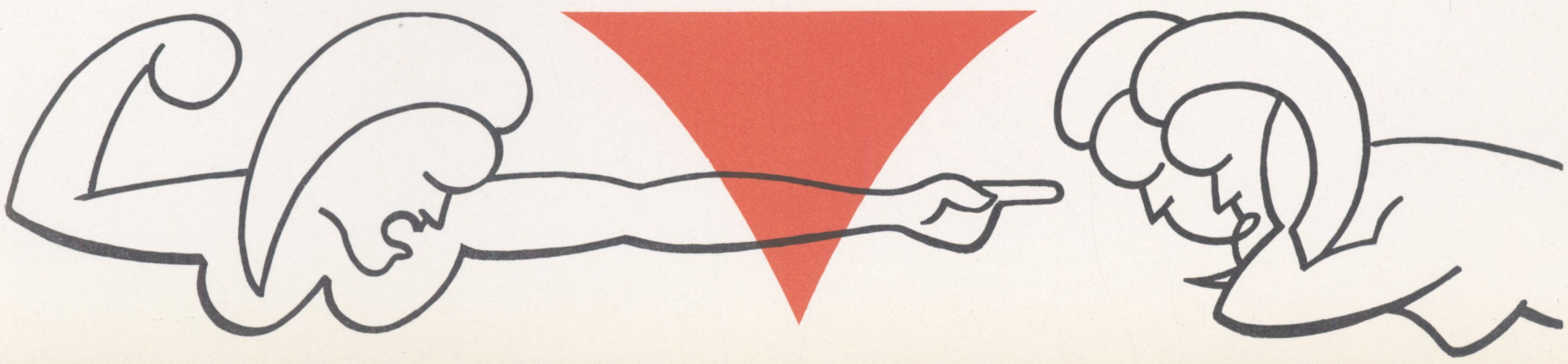
A willing and intelligent patient, she quickly brought out the salient points of the history. She was soon aware of the similarity in the personalities of her father and her husband, as well as those of her mother and mother-in-law. She recognized her headaches as the counterpart of the mother-in-law's temper tantrums and associated the migraines with her own pent-up anger. She saw, too, that incessant work and perfectionistic strivings were efforts to obtain love and approval, as though "the more and better one does, the more one is loved." She saw her role of overwork as a method of escaping sexual activity and still retaining the favor of her husband. Feeling like a helpless, bad child in dealing with the two older women, she did not feel herself a mature, desirable woman in relation to her husband, but feared losing him to the rival (mother-in-law). She steadily improved until she went home for a long holiday week-end. During this time she got into an argument with the mother-in-law, and was able for the first time to give vent to her thoughts and feelings while retaining good control of herself. It was her first realization that anger can be expressed without harm to self or others, a very reassuring experience. She experienced great relief in bringing both the anger and fear into the open. She was somewhat slower in recognizing the murderous fury she felt toward these women and its attendant guilt. The problem of the first marriage was not explored in detail, as it was felt that other factors were of more immediate importance. The children posed no difficulty, as their attitudes and her ways of handling them were sound. The patient's only need was reassurance that her solutions to the special problems entailed by the daughter's deafness were good ones. The husband confirmed the patient's picture of the two mothers. While he tended to blame her mother more, he talked to his own mother, telling her to let his wife alone or they would leave town.

DISPOSITION AND FOLLOW-UP: The patient was seen two times later in follow-up visits. The mild headaches and some dizziness had returned but were not incapacitating. By having a part-time maid and allowing her husband to assist her in little ways, she was learning to accept help without feeling guilty or inadequate.

DISCUSSION: Because her mother's attitude was harsh and rejecting from the first, the patient grew up with the feeling that if her own mother did not love her, she must be very bad indeed. Her efforts to win approval never succeeded because the mother constantly depreciated them. Feelings of inadequacy were added to those of guilt. The normal adolescent rebellion against the parents was impossible for her because it would have added to an already intolerable burden of guilt. Instead, she married, hoping to gain a comfortable relationship like she had had with her father. One reason this marriage failed was the patient's fear and guilt about sex, also a maternal legacy. This failure solidified the feelings of inadequacy which she sought to deny by increasing the quality and quantity of work. Now, however, she had to cope with not only her mother's and her own demands for work, but also her mother-in-law's. Caught in the dizzying spiral of more demands, more inadequacy, more hostility and more guilt, and more demands on herself to assuage the guilt, she was repeating at 30 what she had experienced early in life.

Therapy actually started for her when she was rescued from this situation by the joint efforts of her husband and her physician. Since the patient had neither time nor money for prolonged treatment, many relationships and the deeper feelings were not sufficiently explored. Because of their limitations, the therapist had to decide which problem was most urgent. Following the patient's lead, it soon became clear that her unresolved conflict with her own mother had been duplicated with her mother-in-law. This was the immediate cause of her illness and was, therefore, chosen for the most intensive investigation. As the result of psychotherapy, she had gained many new attitudes toward herself and others. If the husband can protect her from the two older women while these new insights expand and gain strength, she will be able to handle her problems better. It is probable that she will continue to have trouble in the sexual sphere and may need future help with this.

This case illustrates well the effect on adults of unsolved emotional problems of childhood. It further shows the immense value of even one or two good relationships during childhood. It is felt that had she lacked the affectionate reassurances of her half-sister and her father in early life, her reactions would probably have resulted in far graver symptoms and prognosis.



QUESTION: What influence do psychological factors have upon the perception of pain?

ANSWER: Various mechanisms at work in the mind may lessen or accentuate the individual's sensation of pain. People meet pain in different ways; the masochist enjoys it, the stoic accepts and endures it. In persons who are neither stoic nor masochistic, the perception of pain is sometimes modified in accordance with their emotional needs. A familiar example of this is the individual who inflicts painful, or at least uncomfortable, physical measures upon himself as a means of avoiding, or atoning for, a more unbearable psychic pain. Psychiatrists report instances in which patients deliberately cut or burn themselves, utilizing the pain as a welcome distraction from greater suffering in the emotional sphere. Historical accounts suggest that the religious ecstacy of the Christian martyrs involved much more than simple masochism, for they were preoccupied to an extreme degree with emotion-charged convictions, far more important to them than mere pain. It is astounding what severe physical stimuli can be endured when the attention is thus diverted. It has been suggested that each person has a maximum of attention to give to his total situation, and this attention can sometimes be diverted from the source of painful stimuli, lessening the awareness of physical pain. Acting on this theory, San Francisco obstetricians trained in psychiatry permitted their patients to observe the birth of their babies by means of a mirror above the delivery table. They report that, as the mothers become engrossed in watching the birth process, "the pain is reduced to an absolute minimum."

Dr. Frank Fremont-Smith cites another pertinent illustration of the role of attention in respect to pain. One of his sons, at the age of about six, was attacked by a hornet and stung on the face and arm. When he began to scream, his father called to him, saying, "pinch your other arm." The child obeyed, and was surprised to find that his bee stings stopped hurting until he let go. This illustrates the effect of the focus of attention on the perception of pain. It involves the well-known principle of the counter-irritant, long employed by suffering humanity in the form of mustard plasters and the like. That it is equally possible to divert the attention from pain by countermeasures of a psychic nature, is not so widely recognized.

Reference: Abramson, H. A.: Problems of Consciousness, Transactions of Conference, Josiah Macy, Jr. Foundation, New York, Corlies, Macy and Co., 1951, p. 112.

QUESTION: Why do we now hear so little of the mental illness known as "dementia praecox"?

ANSWER: The term, "dementia praecox" has been abandoned in favor of "schizophrenia", a word introduced in 1911 by Bleuler. The Fourth Edition of the Standard Nomenclature of Diseases, published in 1952, omits the centuries-old designation completely, except in the index, which refers the reader to the new one. Two reasons are given for dropping the former term:

By definition, "dementia praecox" suggests a disease which commences early and progresses immutably. Though this is sometimes true, it is by no means descriptive of all cases of this widely-prevalent mental illness.

It was felt that the word "schizo" (splitting) "phrenia" (mind) provided a more accurate diagnostic picture of the patient's withdrawal from reality into a world of his own making. There is a striking incongruity in the thinking and the emotions, as frequently the patient's moods are totally inappropriate to the existing situation. The schizophrenic patient lives in a world of subjective fantasies which permit no accurate evaluation of the real environment. This is not to be confused with the extremely uncommon "split personality", which is a severe disruption of the consciousness of self, in which two different personalities co-exist in the same person. The splitting in schizophrenia is between the patient and reality. Also, the new term does not carry with it any prognostic pessimism, which would be undesirable, since improved techniques in convulsive therapy and psychotherapy are increasing the recovery rates for this disorder in the functioning of the mind.

Reference: Lurie, L. A. and Lurie, M. L.: Psychoses in Children—A Review, J. Pediat. 36:801 (June) 1950.

THE *editors welcome any questions physicians would like to have discussed regarding the clinical handling of psychiatric problems in general practice. Every effort will be made to find answers to such questions and to reflect in these answers the best current psychiatric thinking.*

TUKE

Continued from page 53

of America and Canada received beneficial repercussions. Tuke contended that if mental hospitals were made more habitable, and physicians maintained a more tolerant attitude toward the patients, relatives would be less reluctant to commit their deranged loved ones to institutional care. This would allow earlier therapy, a boon in the treatment of any disease, physical or mental.

Another significant reform was the establishment of the "After Care" Association. This organization was devoted to the rehabilitation of patients discharged from mental institutions. As chairman of this association for many years, Tuke helped hundreds of patients resume their former pursuits. When this was not feasible, he assisted in their adjustment to new modes of life.

With considerable foresight, Tuke permitted his thoughts to dwell on the little-recognized interplay between physical and mental states. This type of thinking laid the groundwork for psychosomatic medicine. As an example of his scientific inquiry, Tuke was intrigued by a newspaper account of a man who had experienced an attack of "rheumatism" in Manchester. Not wishing to suffer alone in a hotel, the patient decided to return to his home in London. Enroute, the train was wrecked, and the man climbed out of his compartment and gingerly picked his way through the debris. To his surprise, he discovered that his symptoms had vanished. Tuke considered this incident carefully, and subsequently wrote a series of articles, later published in the Journal of Medical Science, entitled *Illustrations of the Influence of the Mind upon the Body in Health and Disease.*

To illustrate the reverse phenomenon of the influence of bodily changes on the mind, he collected autopsy material in cases of brain injury associated with psychoses, presenting this as evidence for exploding the belief still widely current that mental illness was the result of demoniac possession.

Other writings by Tuke included a *Manual of Psychological Medicine*, on which he collaborated with John Charles Bucknill. Though the book contained no revolutionary ideas, it played a major role in furthering psychiatric interest in England. In his later years, he wrote a *Dictionary of Medical Psychology*, which contained over 60 classifications of symptoms of psychogenic disorders. This was a valuable contribution to the rapidly-growing body of psychiatric knowledge.

Foremost in his mind, Tuke retained the hope of removing the stigma attached to mental illness. Throughout his life, he endeavored to change the prejudicial attitudes toward this problem, admonishing physicians that "medical men may do much by ignoring the stupid stigma still attached to having been in an asylum." Though a century old, this teaching is still of vital importance today.

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OPERATION MERCIFUL

Continued from page 62

that among the younger children, the primary cause of anxiety was separation from the mother. When surgery is necessary in one so young, special effort seems justified to enable the mother to remain with the child. Should hospital regulations stand in the way of this, some compromise might be considered in fairness to these youngest surgical patients. Kaplan states "one might look forward to the time when hospital routine might be replaced or at least tempered by the introduction of a policy of flexibility. The particular needs of the individual child might be given due consideration in making decisions."

Levy recommends the use of a gentle preliminary anesthetic which will permit the child to be put to sleep in his own room, with his mother beside him. When he awakens, she is with him also, and thus he never feels deserted. If a little child *must* undergo an operation, his physician will want to take every precaution to protect his emotional well-being, as well as his physical health. If these preventive measures are observed, the child may be spared unnecessary fears and anxieties, the parents may be spared future behavior problems in the home, and the physician may be spared a fearful and suspicious attitude on the part of the child. With a little extra attention to the child's emotional needs, the first hospital experience can indeed be operation merciful.

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Face Value

PROBLEM NO. 1, PHYSICAL: Della never had been pretty. Since childhood, she had been the homeliest girl in town. Her nose was much too large and it sat at an undecided angle in her narrow face. Sharp cheekbones emphasized the harsh angularity of her countenance. Her mouth was wide, so she learned rather early not to smile.

When Della was eighteen, the car in which she was riding was struck by a bus. A piece of metal tore loose and caught her full in the face, grinding away a wide swath of skin and muscle. The gash crossed her nose and extended back to her ear. When it healed, Della's never-lovely face was further marred by a thick and savage-looking scar. This was not an ordinary scar. For even after it had served its purpose of providing a surface covering for the injured area, it kept right on growing. Week by week, it became thicker and tougher. From the way it behaved, Della's physician feared

that ultimately it might result in contracture around the mouth and eye. He recommended plastic surgery.

PROBLEM NO. 2, FINANCIAL: Della never had been rich. She had no money saved. And after the accident, she had no job. Formerly, she had been employed as counter girl in a drug store, but now the sight of her was enough to destroy a person's appetite.

PROBLEM NO. 3, PSYCHOLOGICAL: Della never had been popular. As early as grade school, she felt discriminated against because of her appearance. The children, in their native cruelty, took delight in making comparisons. There were always several little beauties to choose among, and many heated arguments ensued about who was prettiest. But there was never any doubt about who was the ugliest.

Della took the brunt of teasing in each new group. After the fun was over, she learned to expect only the detached indifference of all her classmates. Never within her memory had anyone looked in her face and "found her fair." She grew to womanhood with a mind closed against friendship or any hope of happiness.

Suddenly, through no fault of her own, misfortune transformed her into an object of pity, if not of horror, to her fellow man. Always sensitive and seclusive, she now withdrew from social contacts completely, confining herself to her home as much as possible. The townspeople scarcely noticed any difference in her behavior. Indeed, most of them thought that the accident, with her resulting disfigurement, actually would not make much difference in her life.

The people were wrong.

The human mind is rarely so tough that it can withstand such a shock without serious repercussion. Man is unique among the animals in that the foremost source of recognition is his face. Not only recognition, but also a tremendous amount of immediate value is centered in the alignments of that face. For with human beings, it is primarily through the face that one's own self is represented to the world.

Financiers speak of the "face value" of their stocks and bonds, but "face value" as an indication of potential security is not restricted to the world of finance. In the emotional life of man, no security is possible to one whose face is his misfortune. A person who possesses no other favorable attribute but a pleasing face is nevertheless rich in social approbation unless and until his behavior becomes so boorish as to earn disfavor. Those who are confident that their appearance is satisfactory usually seek and enjoy the scrutiny of others. Those who lack this confidence, however, anticipate every human contact with uneasiness and dread. In man, therefore, the face serves a function of its own. Its proper function may be called social attraction. When the face fails in its function, the result is repulsion. Any person whose face continually evokes repulsion is jeopardized in all aspects of his emotional life. As Myerson puts it, "the inner reaction to scrutiny and social evaluation may be as peaceful and as gratifying as a smoothly flowing river, or it may be whipped into whirlpools and vicious cycles of somatic and psychological turmoil."

Among the disfigured, the first realization that one is "not like other people" is fraught with panic. Afterward, there comes the necessity of deciding how to meet the situation. Some, feeling acutely the injustice of society, react with hostility and aggression toward society. Thus, "Scarface", the gangster film of the thirties, while supposedly fiction, dealt with psychological fact.

Most individuals, however, prefer to turn away from society and attempt to cope with unkind truth by resorting to pretense and fantasy. If carried far enough to evolve into a full-fledged denial of reality, this may result in schizophrenia. Probably the most common response is a sort of schizoid withdrawal from the company and gaze of others, which does not proceed as far as actual psychosis. This is so fundamental a response that it is sometimes seen in the very young.

Straith and Millard report the cases of two infants who were born with harelips. Both were conscious of their deformity before they reached the age of two. The little boy came from a family who did not know how to provide the psychological support he so sorely needed, for they kept him hidden away in the back of the house. Whenever strangers came, he grabbed the bed clothes and held them over his misshapen little mouth. It was clear that it would require more than surgery alone to undo the harm which had already been wrought in his mind. The other child, a little girl, was more fortunate. Her family evidently had made no issue of her appearance. She faced her problem in quite a different manner. When she was two years old, her mother found her standing in front of a mirror, pressing the two edges of her split lip together and trying doggedly to make them stay. With this constructive attitude, it was to be expected that, once she received surgical repair, there would be no residue of psychological trauma to be overcome.

Della's emotional background placed her in the same category as the little harelipped boy. Her already pathological dread of meeting strangers was intensified, and she seized upon her disfigurement as an almost welcome barrier between herself and others. She became more and more a victim of what has been referred to as "stage fright on the scene of life."

Her physician knew that Della was faced with several different problems. And he realized that effective therapy could not be achieved without several different solutions.

SOLUTION NO. 1, PHYSICAL: The nearest plastic surgeon was on the staff of a hospital about a hundred miles away. Della's physician consulted him in behalf of his patient. He inquired about the procedure involved in removing the facial keloid. The surgeon replied:

"We excise the superficial layers carefully. Then, in attacking the deeper portion, traction is employed so that any tight points in the scar may be palpated and released. We find that we obtain the best results with full-thickness skin grafts from the neck. This is far superior to skin from any other area. Because of its thickness and softness, it has more motility. And, of course, it's a better color match."

"Is this a one-stage operation?" asked the visitor.

"Oh yes."

The surgeon did not appear to regard it as a particularly formidible operation. So Della's physician ventured another question.

"When you have that nose open," he said, "woudn't it be possible to lower the dorsum, shorten the septum a bit, and perhaps scrape a little off the lateral bony walls?"

The surgeon smiled.

"I am not a cosmetician," he replied.

"I was thinking in terms of vitally-needed psychotherapy."

"On that basis," answered the surgeon, "why, yes. It wouldn't be too much trouble to do a modification of Joseph's operation on your patient."

"Well, if she can get the financial arrangements straightened out, she'll be here."

SOLUTION NO. 2, FINANCIAL: While still at the hospital, Della's physician went to the office of the vocational rehabilitation counselor. He knew that funds are sometimes available for whatever medical services are required to restore the earning capacity of patients fulfilling certain requirements. He was not clear as to what those requirements were. He found that physical restoration may be provided to eliminate certain chronic conditions which constitute an occupational handicap. In Della's case the scar was handicap enough, but her emotional reaction toward the deformity was an even greater barrier to employment. Following a thorough investigation and physical examination, Della was authorized to receive surgical repair.

SOLUTION NO. 3, PSYCHOLOGICAL: Several weeks after the operation, when the swelling had subsided from Della's face, her physician called on her at home. He was more than gratified by what he saw. The contours of her face, while camouflaged by the still-red scars, were now sharply chisled and well-defined. Unsmiling, she looked a trifle disdainful, but the effect was decidedly pleasing.

"Let me take a look at that face." He smiled. "Why, Della, you're going to be a knock-out!"

He did not exaggerate too much, at that.

Della's eyes sought the mirror, then turned away in disgust.

"It was all a waste of time," she

declared. "I never *will* look like anything." She squirmed uneasily, like a fretful child.

So it was going to take more than physical restoration. The physician was not surprised.

"Della," he began, "here is something you might think about when you have time. I have a patient who is an amputee. Just a boy. His leg was mangled when he tried to hop a freight and slipped. That leg is gone, and certainly he knows it. But still, he had a lifelong mental image of his body as it was before. Now and then he starts across the room as though that leg was there."

"And. . .he falls?"

"Yes. He has taken two or three bad spills. Habits of thinking are so ingrained that it will take a long time for him to adjust that mental image to fit his altered body."

This was obviously a new concept for Della. The physician continued.

"The face is a part of one's body image. Probably the most tenacious part of all. Of course you know that your face has been so changed that even your old friends will have to look twice to be sure it's you. So why do you say that you never will look right?"

Della fingered the surface of her nose and cheek. "Well, I don't know," she replied. "I guess it is a good nose, all right. And the scar is flat enough, now. When I put on pancake make-up, it hardly shows at all. Only . . .well . . .my mouth's too big!"

"The girl who won Miss Photo-Flash has a bigger mouth than yours. She won it on her smile."

"Anyway, I'm not the glamour type," she insisted.

"In time, you'll see," he told her. "People will be surprised at the change in your looks. Strangers will look with interest as you pass. Your whole perspective will reverse itself, but it will take time. Just don't close your mind to the possibility that one of these days, you are going to wake up and realize that you are a fine-looking woman."

"That's something to look forward to," she commented.

"I came to see you about another matter, though," he continued. "This new industrial plant which moved to town is hiring people by the dozens. The vocational rehabilitation counselor has lined up an interview for you for the job of receptionist."

Della shuddered and seemed to shrivel up in her chair.

"A receptionist! Anything but that!"

"Why do you say that?"

"All those strange people. You know I'd never be able to talk to them. Oh, that would be an awful job."

"It might be the best thing in the world for you," observed the physician. "How do you feel when you meet a stranger?"

Della hesitated. Then she replied, "Why, I feel that I would like to be invisible. Give anything if I could just *vanish*, lots of times."

"That's not so unusual," he assured her. "Everyone would like to vanish at one time or another. We all have certain things that are easier not to face. But you can't afford to feel that way about people in general, can you?"

"Maybe not."

"Della, you had good reason to withdraw from people in the past. Your reason was based on physical reality. But that reality does not exist any more. Your face is no longer scarred. But your personality is. You still have a problem. But it is an emotional problem now, rather than a physical one."

"I realize that, Doctor."

"Then, if you are willing to work on your own mind, like the surgeon worked on your face, cutting out the troublesome parts and replacing them with new and pliable features, I think you can overcome your difficulties."

"And what is most troublesome?" she asked.

"That dread of people certainly isn't helping you," he said. "If you were in some job where you would have to meet the public, eventually you would be able to forget yourself and meet people on an equal footing. The constant contact with strangers could give you more self-confidence in a short while than you would gain in years of keeping to yourself."

"When you put it that way," she admitted, "it does seem to make sense."

"It all depends on how hard you try to help yourself," he told her. "You may be able to work it out alone. Any time you find yourself wavering, come and talk things over with me. And if working together, we can't see any improvement, then there is always further help to be obtained through psychiatry." His voice softened. "And it would be a shame for a nice-looking girl like you to be a recluse," he concluded.

She stole a look at the mirror again.

"I'll try it," she said suddenly.

"You mean you are going to try to help yourself?" he asked.

"Oh no. Well, yes, that too. I mean I'm going to try and get that receptionist job."

Suggested Reading

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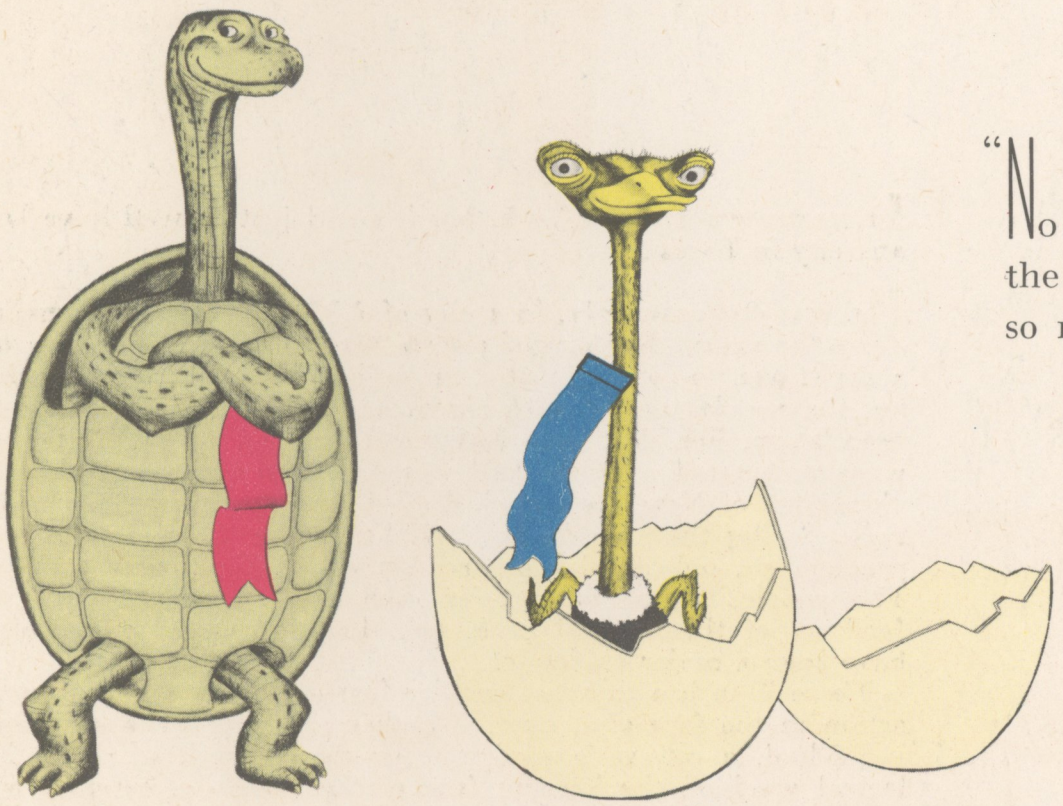
THE HEALTHY FEAR

IT HAPPENED in New York, but it could just as well have been any city in Texas . . .

HE WAS one man only, in a city of 7,000,000. But as he walked about the streets, he changed over 6,000,000 lives. The change was a slight one, to be sure. But it might have been a major one, had not the people reacted with alarm and submitted themeslves for inoculation. For that man had smallpox, and 6,350,000 persons were vaccinated after he had mingled in the city crowds. The physicians of New York worked diligently vaccinating the multitudes during those weeks in 1947. Following this thorough mass prophylaxis, only twelve other cases of smallpox were reported. The people, armed with their own justifiable fears and the facilities of the medical profession, had forestalled what might have been a major epidemic.

There is such a thing as healthy fear—the fear which prompts action in the face of danger. Whether provoked by one infected individual, a city-wide epidemic, or an outbreak of dread biological warfare, the healthy fear of the populace, coupled with the proficiency of the medical profession, will mitigate the ravages of disease.



"No BRANCH of medical science, with the exception of obstetrics, is blessed by so many recoveries as is psychiatry."

KARL A. MENNINGER